State Health Planning and Development Agency, meeting just last week say "...public health is providing care to those who need it and don't want it...If we stopped delivering medical care and just worked on behavior modification and life-style changes, the results would be dramatic."

Someone once said to me, "You should practice medicine and not get involved in societal problems." I think, however, that all of us have an obligation to get involved in society's problems because there is no doubt a society that is sick produces sick people!

Dr. Reid Tuckson from South Central LA quoting a school child said, "...pity and compassion in a world of pain means nothing unless they lead to change." I think we must get very much involved in all the issues of societal decay and the effects on our patients. We need to be compassionate, but as leaders in the community we need to lead by example. We must be intolerant of family violence, drunk driving, drug use, discrimination against HIV-infected individuals, and smoking for that matter.

I am honored to be in the same room with Dr McAfee who has done so much in the campaign against family violence.

I think it is time society takes a hard look at our "civil rights gone wild" problem. We have to take a tough love approach to dealing with individuals who are chronically disabled by the ravages of alcohol and other drugs. I would like to see us look at the boot camp approach to dealing with people who are so disabled by alcohol and other drugs that they are a menace to themselves and others.

I know an HIV-positive woman in Hilo who had been arrested hundreds of times for prostitution and drug possession. She once told me, "I wish I'd been locked into a treatment program before I got this virus."

One of the most frequent visitors to the Hilo Emergency Room over many years was so enslaved by alcohol that most of his life he was involved with traumatic injuries, injuring others, comatose ER visits, ICU admissions, etc. Last weekend he was found dead leaning against a building in Hilo. Mike was in his 40s. We need to help these people help themselves in spite of themselves!

I offer these ideas as something to think about. If you hear me speak on these issues next year, don't be afraid I'm leading HMA in pursuit of windmills.

I want to close by describing what medical practice means to me: It is the 45-year-old cardiac arrest patient whom Dr Linden and I resuscitated in the Hilo ER who said simply, "Thanks for my life." It is the young college student who realized during an ER visit that I had was the doctor who had intubated and resuscitated her at age 13 during an asthma episode. She thanked me for her life and her ability to go to college. This is Dr McAfee's thrill of healing.

Let's all work constantly to preserve this very precious gift we receive from our patients—that of their trust in us. I pledge to do my best to try to achieve the goals of resurrecting the public's trust in us and our pride in this great profession. Thank you for this great honor.

Military Medicine

George B. Lisehora MD
Department of Surgery
Tripler Army Medical Center

Telemedicine Augments Advanced Laparoscopic Surgery

In 1989 laparoscopic cholecystectomy utilizing video cameras and monitors was formally introduced in the United States. The ensuing five years witnessed a relative revolution in gall bladder surgery. It was not long before enthusiasts were followed by skeptics to the nearest course and today, a mere five years later, nearly all gall bladders are removed laparoscopically rather than an open laparotomy. This rapid change was instigated by widespread acknowledgement of the benefits of minimally invasive surgery by the lay press and a populace enthralled with the idea of a painless risk free operation. Patients were referred demanding "that new telescopic laser surgery" and surgeons who did not want to lose a significant portion of their practice were soon performing laparoscopic cholecystectomy with varied amounts of training and supervision.

The collected evidence now shows that in addition to the benefits of decreased post-operative pain, earlier retum to work, and a shorter hospital stay, laparoscopic cholecystectomy, at least initially, also carries an increased risk of significant morbidity. The incidence of common bile duct injury increased in some centers by as much as 12 times. The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) was among the first to recognize and attempt to prevent this complication. It published guidelines in 1990 recommending minimal requirements be met in training and in the supervision of initial cases to safely begin laparoscopic surgery. Since most significant duct injuries occurred during a surgeon's first 10 cases, it was recommended that the surgeon perform his or her first 10 cases under the supervision and guidance of someone who had done at least 25 laparoscopic cholecystectomies. This was difficult enough for surgeons in urban areas and was often impossible for surgeons in rural areas. Experts were flown at great expense all over the country to supervise and help initiate surgeons in the technique of laparoscopic cholecystectomy. Currently, the same enthusiasm is spilling over into more advanced and complex cases such as gastro-esophageal antireflux procedures, colectomy, splenectomy, and small bowel resections. To date, relatively few surgeons are performing such operations laparoscopically but the trend seems clear. Already the same pressures are coming to bear and many fear a high initial incidence of complications if surgeons are forced to ascend the steep learning curve without adequate training and available supervision.

James C. "Butch" Rosser MD is the director of laparoendoscopic surgery at Yale School of Medicine and sits on the New Technologies Board of SAGES with John Payne MD of Kaiser Permanente. Both surgeons have traveled to hospitals other than

their own to assist surgeons interested in progressing to advanced laparoscopic surgical cases. Dr Rosser has envisioned using telemedicine to allow him to be "telepresent" during advanced laparoscopic surgery and actually supervise a case as if he were standing next to the operating surgeon. He discussed these ideas with Dr Payne who recognized the great potential this would have in Hawaii where surgeons who would like help might be on another island. Dr Payne also was aware that the Command at Tripler Medical Center was interested in telemedicine and had already established teleconferencing links with many sites in the Pacific that are currently functioning in a subspecialty consult mode. Dr Payne introduced Dr Rosser to Tripler resulting in a joint venture between Yale School of Medicine, Kaiser Permanente, University of Hawaii, The Queen's Medical Center, and Tripler Army Medical Center.

On September 30, 1994, a six-day advanced laparoscopic surgery "Boot Camp" was held at Tripler. This intense course in advanced laparoscopic techniques and intracorporeal suturing was directed by Dr Rosser and his staff; it was attended by 12 civilian surgeons and 12 military surgeons. All involved were impressed with the scope, depth, and intensity of the training. The course culminated with the teleproctoring of attendees performing advanced laparoscopic surgery on patients while being proctored from a remote site.

On October 5, a Nissen fundoplication was performed laparoscopically in Tripler's operating room while the case was supervised from the hospital's video command center in a different wing seven floors below the operating room. The following day saw the same command center supervise another Nissen fundoplication at Kaiser Hospital approximately 3 miles away. Both operations went very well and the high value of teleproctoring was self-evident. Through a video surgustrator (similar to the video illustrator used by John Madden on Monday Night Football), CD ROM and instant slow motion replay, Dr Rosser has demonstrated that teleproctoring is safe and very effective. The proctorer sees the entire operating room through two video cameras in the room and also receives the image from the laparoscopic camera. The surgeon and assistants wear two-way audio devices and communication is instantaneous. A line, circle or dot drawn with a finger on the touch screen of the surgustrator in the video command center appears at the same site on the operative monitor in the operating room. Images from referenced CD ROM or an instant replay of what just happened may be piped back into the operating room to make teaching points and save operative time in the long run.

We now hope to expand this idea. We had military surgeons from Korea and Okinawa attend this course with the goal of teleproctoring advanced cases in those locations from Tripler in the near future. Drs Payne and Steve Nishida also plan similar demonstrations between Oahu and Neighbor Islands. It is our hope that thoughtful application of this technology will allow surgeons to develop advanced laparoscopic skills and apply them safely and effectively without experiencing a transient increased incidence of significant complications as we witnessed in laparoscopic cholecystectomy. For example, one of our graduating chief residents may be stationed in Korea next year when he is faced with a patient who would be better served by a minimally invasive approach. He might justly feel uncomfortable at the prospect because he had done only a few such cases during his residency. Rather than ship the patient to Tripler, he will only pick up the phone and invite us into his operating room via telemedicine. He will be guided by someone who has done the same operation many times before and knows the potential pitfalls and also knows the techniques of success. It will be just like old times:). [sic]

The views expressed in this article are those of the author and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. government.